COLORADO
Department of Health Care Policy & Financing

FY 2014–2015 Validation of Performance Measures

for

Access Behavioral Care

May 2015

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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Validation of Performance Measures

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Validation Overview

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (MCOs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described at 42 Code of Federal Regulations (CFR) §438.358(b)(2). The purpose of performance measure validation is to ensure that MCOs have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to the specifications required by the state. The state, its agent that is not an MCO, or an external quality review organization (EQRO), can perform this validation. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Colorado Department of Health Care Policy & Financing (the Department), conducted the validation activities as outlined in CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[1]

For fiscal year (FY) 2014–2015, the Department contracted with five behavioral health organizations (BHOs) to provide mental health services to Medicaid-eligible recipients. The Department identified a set of performance measures reported by the BHOs for validation for the measurement period of July 1, 2013 through June 30, 2014 (FY 2013–2014). Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter and enrollment/eligibility data.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Access Behavioral Care Information

Information about **Access Behavioral Care** (**ABC**) appears in Table 1.

Table 1—Access Behavioral Care Information	
BHO Name:	Access Behavioral Care
BHO Location:	10065 E. Harvard Ave., Suite 600, Denver, CO 80231
BHO Site Visit Location:	10065 E. Harvard Ave., Suite 600, Denver, CO 80231
BHO Contact:	Michelle Tomsche, BH Operations Director
Contact Telephone Number:	720.744.5299
Contact Email Address:	Michelle.tomsche@coaccess.com
Site Visit Date:	January 16, 2015

Performance Measures for Validation

HSAG validated a set of performance measures that were selected by the Department. These measures represented HEDIS-like measures and measures developed by the Department and BHOs. The measures were calculated on an annual basis. Table 2 lists the performance measure indicators that HSAG validated and identifies who was responsible for calculating the rates. The indicators are numbered as they appear in the scope document.

Table 2—List of Performance Measure Indicators for Access Behavioral Care		
Indicator		**Calculated by:**
1	Hospital Readmissions Within 7, 30, 90 Days Post-discharge	BHO
4	Behavioral Health Engagement (BHE)*	BHO
8–11	Overall Penetration Rates	Department
8–11	Penetration Rates by Age Group	Department
8–11	Penetration Rates by Eligibility Category	Department
13	Follow-up Appointments Within Seven (7) and Thirty (30) Days After Hospital Discharge	BHO
14	Percent of Members With SMI With a Focal Point of Behavioral Health Care	BHO
15	Improving Physical Healthcare Access	Department
16	Inpatient Utilization (per 1000 members)	BHO
17	Hospital Average Length of Stay (LOS)	BHO
18	Emergency Department Utilization (per 1000 members)	BHO

* For the FY 2014–2015 Colorado BHO performance measure validation (PMV) activity, the measure will be validated, but no penalties will be associated with this measure.

Description of Validation Activities

Preaudit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. The Department provided a list of the indicators selected for validation, the indicator definitions (Appendix A) and the indicator specifications. The Department and BHOs worked together to develop this document, which was first used for performance measure validation purposes in FY 2007–2008. The Department and BHOs worked on additional improvements of these measures and the specification document in the Department's Behavioral Health Quality Improvement Committee meeting, and a revised specification document was used for FY 2014–2015 reporting purposes.

HSAG prepared a documentation request, which included the Information Systems Capabilities Assessment Tool (ISCAT), Appendix V of the CMS Performance Measure Validation Protocol. In collaboration with the Department, HSAG customized the ISCAT to collect the necessary data consistent with Colorado's mental health service delivery model. The ISCAT was forwarded to the BHOs with a timetable for completion and instructions for submission. When requested, HSAG fielded ISCAT-related questions directly from the BHOs during the pre-on-site phase.

HSAG prepared an agenda for each BHO, describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were then forwarded to the respective BHOs prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the BHOs to discuss any outstanding ISCAT questions and on-site visit activities.

Validation Team

The HSAG PMV team was assembled based on the full complement of skills required for the validation and requirements of the particular BHO. Some team members, including the lead auditor, participated in the on-site meetings; others conducted their work at HSAG offices. Table 3 describes each team member's role and expertise.

Table 3—Validation Team

Name and Role	Skills and Expertise
David Mabb, MS, CHCA *Director, Audits; Lead Auditor*	Certified HEDIS compliance auditor with extensive experience in leading HEDIS audits and PMV activities in multiple states. Additional experience in statistics, data analysis and management, state Medicaid programs, and source code programming knowledge.
Timea Jonas *Audit Specialist; Secondary Auditor*	Auditor-in-training; claims processing and auditing experience, healthcare fraud analysis experience.
Tammy GianFrancisco *Project Leader*	Project coordination and communication.

Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. The list below provides information on how HSAG conducted an analysis of these data:

- *Information Systems Capabilities Assessment Tools (ISCATs)* were requested and received from the BHOs and the Department. Upon receipt by HSAG, the ISCATs underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- *Source code (programming language) for performance measures* was requested and was submitted by the Department and the BHOs. HSAG completed line-by-line review of the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any).
- *Performance measure reports for FY 2014–2015* were reviewed by the validation team. The team also reviewed previous reports to assess trending patterns and rate reasonability.
- *Supporting documentation* included any documentation that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up.

On-Site Activities

HSAG conducted on-site visits with the Department and the BHOs. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows.

- **Opening session**—included introductions of the validation team and key BHO and Department staff involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—included a review of the information systems, focusing on the processing of claims, encounter, consumer, and provider data. HSAG performed primary source verification on a random sample of consumers, validating enrollment and encounter data for a given date of service within both the membership and claims/encounter data systems. Additionally, the review evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- **Review of ISCAT and supportive documentation**—included a review of the processes used to collect, store, validate, and report performance measure data. This session was designed to be interactive with key BHO and Department staff. The goal of this session was to obtain a complete picture of the degree of compliance with written documentation. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Closing conference**—provided a summary of preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site visit activities.

HSAG conducted several interviews with key **ABC** and Department staff members involved with any aspect of performance indicator reporting. Table 4 displays a list of **ABC** key interviewees.

Table 4—List of Access Behavioral Care Participants	
Name	**Title**
Michelle Tomsche	BHI Program Director, Colorado Access
Kristin Brown	BH Operations Coordinator
Mary H. Fischer	Director of Claims, Colorado Access
Julie McNamara	Director, System Performance, Colorado Access
Anne Martin	Decision Support Analyst BH, Colorado Access
Chris Lutzka	Manager, Apps/Data Services, Colorado Access
Karl Cline	ABC NE Region BHO Director
Greg Jensen	Director, Decision Support, Colorado Access
Julie Salazar	Senior Decision Support Analyst, Colorado Access
Christy Weber	EDI Business Analyst
John Kiekhaefer	Operations Manager
Jeni Sargent	Director, Eligibility/Enrollment
Suzanne Kinney	Behavioral Health Quality Program Manager
Ann Brunker	Senior Business Analyst
Marie Steckbeck	Supervisor of Operations
List of Department Observers	
Name	**Title**
Jerry Ware	Quality and Compliance Specialist

Data Integration, Data Control, and Performance Measure Documentation

Several aspects involved in the calculation of performance indicators are crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. Each of the sections below describes the validation processes used and the validation findings. For more detailed information, please see Appendix B.

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, including encounter data and eligibility data, must be carefully controlled and validated. HSAG validated the data integration process used by the Department and the BHO. This validation included a comparison of source data to warehouse files and a review of file consolidations or extracts, data integration documentation, source code, production activity logs, and linking mechanisms. By evaluating linking mechanisms, HSAG was able to determine how different data sources (i.e., claims data and membership data) interacted with one another and how certain elements were consolidated readily and used efficiently. Overall, HSAG determined that the data integration processes used by the Department and the BHO were:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure of **ABC** must support all necessary information systems. Each quality assurance practice and backup procedure must be sound to ensure timely and accurate processing of data, as well as provide data protection in the event of a disaster. HSAG validated the data control processes used by **ABC**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, HSAG determined that the data control processes in place at **ABC** were:

☒ Acceptable

☐ Not acceptable

Performance Measure Documentation

Complete and sufficient documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by **ABC** and the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, HSAG determined that the documentation of performance measure data collection and calculations by **ABC** and the Department was:

☒ Acceptable

☐ Not acceptable

Validation Results

HSAG identified overall strengths and areas for improvement for **ABC**. In addition, HSAG evaluated **ABC**'s data systems for the processing of each type of data used for reporting the performance indicators. General findings are indicated below.

Strengths

As in prior years, **ABC** continued to have a collaborative relationship with Colorado Access, the BHO's administrative service organization (ASO). Performance calculation and reporting were performed by the same cohesive team, with a high degree of technical expertise. In 2014, **ABC** experienced major system change along with assuming responsibility for an additional product line (substance use disorder [SUD]), which resulted in an increase in membership. However, even with these changes, the BHO was able to provide quality services to its members and maintain its performance level throughout the year.

Areas for Improvement

During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. However, the BHO's analytical staff members were responsive and corrected these discrepancies prior to the generation of this report. The corrected data files were resubmitted for review. After the file review, HSAG noted no further issues or concerns. **ABC** should continue to work closely with the Department to resolve the discrepancies with the flat files not matching the 837 files in the State's Medicaid Management Information System (MMIS) system.

Eligibility Data System Findings

HSAG had no concerns with the way **ABC** received and processed eligibility data. As in prior years, Colorado Access obtained enrollment information via State portal. **ABC** received a full snapshot of the enrollment information monthly. In addition, the BHO also obtained daily change files. The eligibility data were loaded into a data scrubber, where business rules were applied and any inaccurate records removed, to ensure that only accurate and clean enrollment information was being loaded into the BHO's transactional system. For measure production, the eligibility information was reconciled with the monthly full snapshot. In case of any discrepancy, real-time eligibility check was available via the Department's portal.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns with the way **ABC** received, processed, and reported claims and encounter data. In November 2013, **ABC** changed its claims processing system from PowerStep to QNXT. QNXT is operated by TriZetto. The system change had adequate overview, which was well documented. The community mental health centers (CMHCs) uploaded electronic files in an 837 file format to the Colorado Access Web file. The files then were copied to a file share between

Colorado Access (COA) and TriZetto, where they went through a validation process prior to being loaded into the claims processing system (QNXT). Daily error reports were generated for added quality assurance. In addition, monthly quality review meetings were also in place to ensure claims data accuracy.

Paper claims were scanned using Optical Character Recognition (OCR) and uploaded to TriZetto via secure FTP site daily, where the image was converted to 837 file format and loaded into the claims processing system, QNXT. TriZetto randomly audited processed claims for each line of business. **ABC** had an excellent process in place for oversight of its claims processing vendor. In addition to TriZetto's claims audit, **ABC** also performed a review on the processed claims for added quality control. **ABC** performed 100 percent audits on professional claims exceeding the threshold of $5,000 and on facility claims exceeding the threshold of $20,000.

Prior to submitting encounters to the Department, all 837 files underwent an internal review process, including a code validity check to determine if these files were acceptable for submission.

Actions Taken as a Result of the Previous Year's Recommendations

In response to last year's recommendation, **ABC** continued to work closely with the Department to address and resolve any issues identified in the scope document.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators, which are defined in Table 5.

Table 5—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the Department's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to indicators for which (1) the BHO rate was materially biased or (2) the BHO was not required to report.
No Benefit (NB)	Indicator was not reported because the BHO did not offer the benefit required by the indicator.

According to the protocol, the validation finding for each indicator is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance indicator by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of R.

Table 6 through Table 16 below displays the review findings and key recommendations for **ABC** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Access Behavioral Care Performance Indicator 1: Hospital Readmissions Within 7, 30, 90 Days Post-discharge
Findings
ABC calculated this rate. During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. **ABC** corrected the issue and resubmitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file and identified no further issues. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation. In addition, **ABC** should continue to verify that the correct data field is being captured for reporting purposes.

Table 7—Key Review Findings for Access Behavioral Care Performance Indicator 4: Behavioral Health Engagement (BHE)*
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit. HSAG also performed primary source verification on-site and identified no discrepancies.
Key Recommendations
◆ This was the first year the BHO reported this measure. For the next measurement year, **ABC** should obtain the negative diagnosis history to ensure that accurate data will be reported for this indicator.

* For the FY 2014–2015 Colorado BHO PMV activity, the measure will be validated, but no penalties will be associated with this measure.

Table 8—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Overall Penetration Rates
Findings
This rate was calculated by the Department based on encounter data received from **ABC** quarterly. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates and identified no issues or concerns.
Key Recommendations
◆ **ABC** should continue to inspect, for accuracy and completeness, encounter data received from the CMHCs and providers.

Table 9—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Penetration Rates by Age Group
Findings
This rate was calculated by the Department based on encounter data received from **ABC** quarterly. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates and identified no issues or concerns.
Key Recommendations
◆ **ABC** should continue to inspect, for accuracy and completeness, encounter data received from the CMHCs and providers.

Table 10—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Penetration Rates by Eligibility Category
Findings
This rate was calculated by the Department based on encounter data received from **ABC** quarterly. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates and identified no issues or concerns.
Key Recommendations
◆ **ABC** should continue to inspect, for accuracy and completeness, encounter data received from the CMHCs and providers.

Table 11—Key Review Findings for Access Behavioral Care Performance Indicator 13: Follow-up Appointments Within Seven (7) and Thirty (30) Days After Hospital Discharge)
Findings
ABC calculated this rate. During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. **ABC** corrected the issue and resubmitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file and identified no further issues. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation. In addition, **ABC** should continue to verify that the correct data field is being captured for reporting purposes.

Table 12—Key Review Findings for Access Behavioral Care Performance Indicator 14: Percent of Members With SMI With a Focal Point of Behavioral Health Care
Findings
ABC calculated this rate. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit. HSAG performed primary source verification on-site and identified no discrepancies.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation.

Table 13—Key Review Findings for Access Behavioral Care Performance Indicator 15: Improving Physical Healthcare Access
Findings
This rate was calculated by the Department based on encounter/claims files received from BHOs, MCOs, and Fee for Service providers. Programming code used for calculation of this rate was reviewed by HSAG, and no concerns were noted. Auditors conducted interviews with key staff members from the Department, and HSAG determined that claims and encounter data collection processes were accurate and met standards.
Key Recommendations
◆ **ABC** should continue its effort to inspect completeness and accuracy of the encounter data received from the CMHCs and providers.

Table 14—Key Review Findings for Access Behavioral Care Performance Indicator 16: Inpatient Utilization (per 1000 members)
Findings
ABC calculated this rate. During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. **ABC** corrected the issue and resubmitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file and identified no further issues. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation. In addition, **ABC** should continue to verify that the correct data field is being captured for reporting purposes.

Table 15—Key Review Findings for Access Behavioral Care Performance Indicator 17: Hospital Length of Stay (LOS)
Findings
ABC calculated this rate. During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. **ABC** corrected the issue and resubmitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file and identified no further issues. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation. In addition, **ABC** should continue to verify that the correct data field is being captured for reporting purposes.

Table 16—Key Review Findings for Access Behavioral Care Performance Indicator 18: Emergency Department Utilization (per 1000 members)
Findings
ABC calculated this rate. During the on-site visit, it was found that the incorrect data field was captured for the inpatient services. **ABC** corrected the issue and resubmitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file and identified no further issues. HSAG reviewed **ABC**'s programming code used for calculation of this rate and identified no concerns. Source code review result was provided to the BHO prior to the on-site visit.
Key Recommendations
◆ To determine reasonableness of data, **ABC** should continue data monitoring for rate calculation. In addition, **ABC** should continue to verify that the correct data field is being captured for reporting purposes.

Table 17 lists the validation result for each performance measure indicator for **ABC**.

Table 17—Summary of Results		
Performance Indicator		**Validation Result**
1	Hospital Recidivism	**Report**
4	Behavioral Health Engagement (BHE)*	**Report**
8–11	Overall Penetration Rates	**Report**
8–11	Penetration Rates by Age Category	**Report**
8–11	Penetration Rates by Medicaid Eligibility Category	**Report**
13	Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)	**Report**
14	Percent of Members With SMI With a Focal Point of Behavioral Health Care	**Report**
15	Improving Physical Healthcare Access	**Report**
16	Inpatient Utilization	**Report**
17	Hospital Average Length of Stay	**Report**
18	Emergency Department Utilization	**Report**

***** For the FY 2014–2015 Colorado BHO PMV activity, the measure will be validated, but no penalties will be associated with this measure.

Indicators

Indicator		Calculated by:
1	Hospital Readmissions Within 7, 30, 90 Days Post-discharge	BHOs
4	Behavioral Health Engagement (BHE)*	BHOs
8–11	Overall Penetration Rates	Department
8–11	Penetration Rates by Age Group	Department
8–11	Penetration Rates by Eligibility Category	Department
13	Follow-up Appointments Within Seven (7) and Thirty (30) Days After Hospital Discharge	BHOs
14	Percent of Members With SMI With a Focal Point of Behavioral Health Care	BHOs
15	Improving Physical Healthcare Access	Department
16	Inpatient Utilization (per 1000 members)	BHOs
17	Hospital Length of Stay (LOS)	BHOs
18	Emergency Department Utilization (per 1000 members)	BHOs

* For the FY 2014–2015 Colorado BHO PMV activity, the measure will be validated, but no penalties will be associated with this measure.

The Department collaborated with the BHOs to create a scope document that serves as the specifications for the performance measures being validated. Following is the *FY 2014 BHO-HCPF Annual Performance Measures Scope Document, Version 6, Created: October 29, 2014.* Please note that the complete scope document is not listed in this appendix. The Table of Contents, Introduction, and Definitions pages and corresponding page numbers have been modified for use in this report; however, the verbiage for the measures validated under the scope of the review is reproduced in its entirety.

FY 2014

BHO-HCPF Annual Performance Measures Scope Document

Behavioral HEALTHCARE

Version 6
Created: October 29, 2014

Table of Contents

(Listed According to BHO Contract)

Introduction

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs). Some of these measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data.

Performance Measures Indexed by Agency Responsible for Calculation

Calculated by the BHO:

Calculated by HCPF:

Definitions

24 Hour Treatment Facility – A residential facility that has 24-hr professional staffing and a program of treatment services and includes PRTF and TRCCFs. Does not include Nursing Facilities or Alternative Care Facilities (ACF) defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients.

Age Category – Based on HEDIS age categories: 0-12 (Child), 13-17 (Adolescent), 18-64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

Covered Mental Health Diagnoses: The BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain mental health diagnoses are covered. These specific diagnoses can be found below or in the BHO Medicaid BHO contract Exhibit D. Only those services that cover mental health, with the exception of services related to Assessment, Prevention, and Crisis procedure coding as a diagnosis may have yet to be ascribed, will be included in the calculations of performance measures.

Covered Mental Health Diagnoses			
295.00-298.99	**300.00-301.99**	**307.10-309.99**	**311-314.99**

Covered Substance Use Disorder Diagnosis: Starting January 1, 2014, the BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain substance use disorder diagnoses be covered. These diagnoses can be found below or in the Medicaid BHO Contract in Amendment 13. For purposes of the performance measures calculations, the following diagnosis codes are acceptable.

Covered Substance Use Disorder Codes
291; 291.1; 291.3; 291.5; 291.81; 291.89; 291.9; 292; 292.11-.12; 292.81; 292.83-.85; 292.89; 292.9
303; 304; 305; 303.0; 303.9; 304.0-304.6; 305.0; 305.1; 305.2;305.3; 305.4; 305.5; 305.7; 305.9
303.00-303.03; 303.90; 304.00-.03; 304.10-.13; 304.20-.23; 304.30-.33; 304.40-.43; 304.50-.53;304.60-.63
305.00-03; 305.10-.13; 305.20-.23; 305.30-.33; 305.40-.43; 305.50-.53; 305.60-.63; 305.70-.73; 305.90-.93

Fiscal Year (FY) or State Fiscal Year (SFY): Based on the state fiscal year July 1-June 30 of the measurement year

HCPF— The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS—Healthcare Effectiveness Data and Information Set

Hospital Admit – An admission to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

Hospital Discharge – A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list

of discharges from the State hospital who are not eligible at the time of hospital admission should be included in the measure if eligibility is discontinued 1 day before the admission date. Adult members on the list of discharges from the State hospital who are eligible at the time of hospital admission, but who lose eligibility during the hospital stay should also remain on the hospital discharge list.

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Member Months: Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Penetration Rate is the number of members who received at least one service (paid or denied claim) divided by the number of FTE enrolled in the Medicaid mental health managed care program.

Per 1000 members – A measure based on total eligible members per 1000.

Quarter – Based on fiscal year quarters (Jul-Sep, Oct-Dec, Jan-Mar, Apr-Jun)

Indicator 1: Hospital readmissions within 7, 30, 90 days post-discharge

Description: Proportion of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis and readmitted for another hospital episode for treatment of a covered mental health diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Two indicators are provided: 1) **Non-State:** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The population is based on discharges (e.g., one member can have multiple discharges).

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital during the specified fiscal year
- **All Hospitals:** Total number of Member discharges from all hospitals during the specified fiscal year

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.
- **All Hospitals:** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source(s): Denominator: Number of Member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by HCPF. Numerator: Admissions from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, will be provided by the HCPF.

Calculation of Measure: BHO, with some data provided by HCPF

Ratios: Child 7 day readmit/Non-state Child discharges; Child 30 day readmit/Non-state Child discharges; Child 90 day readmit/Non-state Child discharges; Child 7 day readmit/All Hospital Child discharges; Child 30 day readmit/All Hospital Child Discharges; Child 90 day readmit/All Hospital Child discharges; Adolescent 7 day readmit/Non-state Adolescent discharges; Adolescent 30 day readmit/Non-state Adolescent discharges; Adolescent 90 day readmit/Non-state Adolescent discharges; Adolescent 7 day readmit/All Hospital Adolescent discharges; Adolescent 30 day readmit/All Hospital Adolescent Discharges; Adolescent 90 day readmit/All Hospital Adolescent discharges; Adult 7 day readmit/Non-state Adult discharges; Adult 30 day readmit/Non-state Adult discharges; Adult 90 day readmit/Non-state Adult discharges; Adult 7 day readmit/All Hospital Adult discharges; Adult 30 day readmit/All Hospital Adult Discharges; Adult 90 day readmit/All Hospital Adult discharges; Older Adult 7 day readmit/Non-state Older Adult discharges; Older Adult 30 day readmit/Non-state Older Adult discharges; Older Adult 90 day readmit/Non-state Older Adult discharges; Older Adult 7 day readmit/All Hospital Older

Adult discharges; Older Adult 30 day readmit/All Hospital Older Adult Discharges; Older Adult 90 day readmit/All Hospital Older Adult discharges; All ages 7 day readmits/All ages All hospital discharges; All 30 day readmits/All ages all hospital discharges; All 90 day readmits/All ages hospital discharges; All 7 day readmits/Non-state hospital discharges; All 30 day readmits/Non-state hospital discharges; All 90 day discharges/Non-state hospital discharges

Benchmark: Overall BHOs.

Indicator 4: Behavioral Health Engagement (BHE)

Description

The percentage of new members diagnosed with a covered diagnosis who were engaged by the behavioral health organization, as defined below:

- *Engagement:* New members who received at least four engagement services within 45 days of the initial visit or episode. The initial visit may be counted as the first engagement service.
- This measure will have two Indicators. Indicator 4a will be for mental health engagement and Indicator 4b will be for substance use disorder engagement. For Indicator 4a, use the mental health diagnoses in Table A and for Indicator 4b use the substance use disorder diagnoses referenced in Table A.
- Members will be in one of the two tracks (MH or SUD) based on the initial service diagnosis. Members in the mental health track can have substance use services count towards their engagement and members in the substance use track can have mental health services count towards their engagement. To finalize the measure, break out numerator and denominator by each track per age group.

Definitions

Intake Period	July 1, 2013 to May 16, 2014. The Intake Period is used to capture new episodes.
Index Episode Start Date (IESD)	The earliest visit during the Intake Period with one of the selected covered diagnoses from Table A. *For an outpatient, or ED visit (not resulting in an inpatient stay) claim/encounter,* the IESD is the date of service. *For an inpatient (acute or non-acute) claim/encounter,* the IESD is the date of discharge. *For an ED visit that results in an inpatient stay,* the IESD is the date of the inpatient discharge. *For direct transfers*, the IESD is the discharge date from the second admission.
Negative Diagnosis History	A period of 90 days before the IESD, during which the member had no claims or encounters with a diagnosis from Table A. *For an inpatient claim/encounter,* use the admission date to determine the Negative Diagnosis History. *For ED visits that result in an inpatient stay,* use the ED date of service to determine the Negative Diagnosis History. *For direct transfers,* use the first admission date to determine the Negative Diagnosis History.

Eligible Population

Age	All members are included in this measure. Report age stratifications and a total rate. Report the age as of the IESD as defined below: • 0 -12 years • 13 - 17 years • 18 - 64 years • 65+ years • Total The total is the sum of the age stratifications.
Continuous enrollment	The IESD through 45 days after the IESD, with no gaps of enrollment during the 45-day period. Note: the member does not need to be continuously enrolled for the negative diagnosis history period since any new member for the BHO with a covered mental health diagnosis should receive engagement services following the visit or episode.
Event/ diagnosis	New episode during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator.
Step 1	Identify the Index Episode Start Date (IESD). Identify all members during the Intake Period that had at least one of the following: Any claim or encounter with a diagnosis from Table-A. Notes: For members with more than one episode, use the first episode. For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.
Step 2	Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis in Table-A or a service from Table-C during the 90 days before the IESD. Notes: • Using a 90-day negative diagnosis history is meant to help define new members, and exclude medication only members that are seen infrequently. • For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. • For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. • For Indicator 4b (SUD engagement) there will be not be a full negative diagnosis history for individuals diagnosed between January through March, since the SUD benefit started January 1, 2014. For the negative diagnosis history for these months, go back as far as you are able to determine a negative diagnosis history.
Step 3	Calculate continuous enrollment. Members must be continuously enrolled without any enrollment gaps from the IESD through 45 days after the IESD.

Table A: Covered Mental Health Diagnoses (Indicator 4a)			
295.00-298.99	**300.00-301.99**	**307.10-309.99**	**311-314.99**
Covered Substance Use Disorder Codes (Indicator 4b)			
291; 291.1; 291.3; 291.5; 291.81; 291.89; 291.9; 292; 292.11-.12; 292.81; 292.83-.85; 292.89; 292.9; 303; 304; 305; 303.0; 303.9; 304.0-304.6; 305.0; 305.1; 305.2;305.3; 305.4; 305.5; 305.7; 305.9; 303.00-303.03; 303.90; 304.00-.03; 304.10-.13; 304.20-.23; 304.30-.33; 304.40-.43; 304.50-.53;304.60-.63; 305.00-03; 305.10-.13; 305.20-.23; 305.30-.33; 305.40-.43; 305.50-.53; 305.60-.63; 305.70-.73; 305.90-.93			

Table B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

Numerator

Engagement

Four or more engagements (Table C below) within 45 days after the date of the initial visits (IESD encounter). The initial visit may count as one engagement service. Services can occur on the same day. Table C services are used for both Indicator 4a and 4b to account for those individuals who have co-occurring disorders and may receive several types of services.

The intent of this measure is to ensure members receive ongoing engagement within the first 45 days of an initial visit. Therefore, with the exception of the monthly supported housing (H0044). Engagement services for the monthly supported housing (H0044) may only count as one service during the 45-day period. The "per day" supported housing (H0043) can be counted multiple times within the 45 day period.

Examples:

- A member receiving two monthly supported housing services (H0044) in the 45-day period should count as one service.
- A member receiving two supported housing services (H0043) in the 45-day period may count as two services.

Rates

Rates are reported by Indicator. For each Indicator (4a and 4b) report age group and total. Report the percentage who received one, two, three, and four or more services within the 45 days from the IESD.

Table C: Numerator Codes to Identify Engagement Services

CPT	HCPCS
90791-90792; 90832-90834; 90836-90840 90846-90847; 90849; 90853; 90875-90876 90887; 96101-96103; 96116; 96118-96120 96372; 97535; 97537; 99201-99205; 99212-99215; 99211; 99304-99310; 99324-99328 99334-99337; 99341-99345; 99347-99350 99441-99443	G0176-G0177; H0001-H0002; H0004-H0006; H0020; H0031-H0034 H0036-H0040; H0043; H0044; H2000-H2001; H2011-H2012; H2014-H2018; H2021-H2027; H2030-H2033; M0064; S5150-S5151;S9445; S9453-S9454; S9480; S9485; T1016-T1017
Only one monthly supported housing service (H0044) may be counted towards the numerator.	

Indicators 8-11: Penetration rates (including breakouts by HEDIS age groups, Medicaid eligibility category, race, and service category)

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by HEDIS age group, Medicaid eligibility category **(refer to Table 4),** race **(refer to Table 4),** and service category **(refer to Table 5 for HEDIS specs and additional place of service (POS) and service codes.)**

- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Race/ethnic group is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Service category is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.
- Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are analyzed.
- All enrollment spans identified as: enrollment begin date <= the last date of the fiscal year (6/30) AND enrollment end date >= the first date of the fiscal year (7/1).
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
- NOTE: The Data Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

Denominator: Number of FTE Enrollees

Numerator: Members with any MH service in the specified fiscal year (12-month period) in each age group, Medicaid eligibility category, race/ethnic group, and by service category grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care.

Data Source(s): BHO claims/encounter file (both paid and denied claims/encounters will be used).

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

TABLE 4

Medicaid Eligibility and Race/Ethnicity Categories

Medicaid Eligibility Category is determine by the member's most recent Medicaid eligibility span during the fiscal year

Eligibility Type Code	Description
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP Adults
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
020	BCCP-WOMEN BREAST&CERVICAL CAN
030	MAGI ADULTS
031	BUYIN: WORKING ADULT DISABLED
032	BUYIN: CHILDREN W/ DISABILITIES

Medicaid Race Category is determined by the member's most recent Medicaid eligibility span during the fiscal year.

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ASIAN
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

TABLE 5

Penetration Rates by Service Category

Description: The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year.

- *Any service*
- *Inpatient*
- *Intensive outpatient or partial hospitalization*
- *Outpatient or ED*
- *Substance Use Disorder*

Calculations

Counts

- Members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits.
- Count members in the *Any Services* column for any service during the measurement year. is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.

Age

- Members should be reported in the respective age category as of the last date of the fiscal year

Denominator

1. Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are pulled from the DSS. The data are pulled after the end of the prior fiscal year thus allowing for retroactive enrollment to be captured.
2. The enrollment spans are converted to a number of days enrolled by taking the enrollment end date minus the enrollment begin date plus one. The days are then summed and divided by 365 (366 in leap years). This creates a member year or FTE calculation.
3. Each client's age group, race, and eligibility type are determined using the most recent data stored in MMIS client demographic and eligibility records.

Numerator

1. Encounter data submitted by the BHOs are analyzed in the Colorado Medicaid decision support system (DSS).
2. The encounters are grouped by Medicaid managed care mental health provider (BHO) number, and the number of unique client IDs are summed to obtain the number of clients served.
3. For unique client IDs by age, race, and eligibility type the client's demographic information is pulled and then joined to the encounter information, by Medicaid client ID, so that each BHO encounter is associated with an age group, race code and eligibility type

Member months

Report all member months during the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables.* Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit. Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

Substance Use Disorder

Client receiving SUD treatment will be counted in the overall BHO Penetration rate. In addition, Clients receiving SUD treatment will be shown separately in the breakout by service category.

- Include all **encounters** with an approved SUD diagnosis
- **291.XX, 292.XX, 303.XX, 304.XX, 305.XX**

Also include encounters with covered SUD procedure code

- **H0001, H0004, H0005, H0006, H0020, H0038**
- **S3005, S9445, T1007, T1019, T1023**

Inpatient

- Include inpatient **care** at either a hospital or treatment facility with a covered mental health diagnosis as the principal diagnosis:
- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

One of the following criteria should be used to identify inpatient services.

- An Inpatient Facility code in conjunction with a covered mental health diagnosis o***r***
- DRGs (Table MPT-B)

Include discharges associated with residential care and rehabilitation

Codes to Identify Inpatient Service

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919
ATU codes : 190, H2013, H0018AT, H0017
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

Table MPT-B Codes to Identify Inpatient Services

MS—DRG
876, 880-887

Codes to Identify Intensive Outpatient and Partial Hospitalization Services:

HCPCS	UB Revenue	
Visits identified by the following HCPCS, UB Revenue, and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,	
CPT		**POS**
, 90845, 90847, 90849, 90853, , 90870, 90875, 90876; 90791, 90792, 90832, 90834, 90837	***WITH***	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99201-99205, 99211-99219, 99241-99245, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99366-99368, 99441-99443	***WITH***	52

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
96101-96103, 96105, 96110, 96111, 96116, 96118-20, 96125, 90832, 90834, 90837, 90839	G0155, G0176, G0177, G0409, H0002, H0004, H0023, H0025, H0031,H0032 H0034, H0036, H0037, H0039, H0040, H0044, H1011, H2000, H2010, H2011, H2013-H2020, H2027, H2033, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S5150, S5151, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x

CPT		POS
, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 90791, 90792, 90785, 90846	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99

CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.	
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537	045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

* POS 53 identifies visits that occur in an outpatient, intensive outpatient, or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2014 specifications.

Indicator 13: Follow-up appointments within seven (7) and thirty (30) days after hospital discharge

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health diagnosis to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) **Non-State:** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30) **All hospital:** Follow-up rates for member discharges from all hospital episodes for a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.
Numerators: Total number of discharges with an outpatient service (**see Table 7)** within 7 and 30 days (the 30 days includes the 7-day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See codes in **Table 7** for follow-up visit codes allowed.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.
All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Denominators: The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.
All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, ages 6-20 and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: An outpatient visit, intensive outpatient encounter or partial hospitalization provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO;

Benchmark: HEDIS and all BHOS

TABLE 7

Description

The percentage of discharges for members 6-20 years of age and 21-64, and 65+ who were hospitalized for treatment of a covered mental health diagnosis and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates for each age group are reported.

1. The percentage of members who received follow-up within 30 days of discharge
2. The percentage of members who received follow-up within 7 days of discharge

Eligible Population	
Ages	Two age categories are identified, ages 6-20, 21-64, and 65+
Continuous enrollment	Date of discharge through 30 days after discharge.

Allowable gap	No gap in enrollment except for State hospital stays (age 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If readmission or direct transfer to an acute facility follows the discharge for any covered mental health diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health diagnosis, it is probably for a related condition. In some cases, data associated with member transfers from inpatient care to less acute 24-hour care that are initiated by the Department of Youth Corrections, the Department of Human Services, or similar organizations are not available to the BHO. In these cases, an affected member may be included in the denominator, even though the transfer prevents a follow-up visit from occurring. Thus, the lack of available data reflecting these transfers will result in a lower percentage of completed follow-up visits for the BHO. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any covered mental health diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify non-acute care.
Exclusion	Because residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Codes to Identify Non-acute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x, 28x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF)				

Administrative Specification	
Denominator	The eligible population.
Numerators	
30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.
7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90839	G0155, G0176, G0177, G0409, G0410, G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
, 90845, 90847, 90849, 90853, , 90870, 90875, 90876, 90791, 90792, 90832, 90834, 90837, 90791, 90792	***WITH***	03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any covered diagnosis code.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

- Note: The specification presented here for the Follow up Post Discharge performance indicator are closely based upon HEDIS 2014 specifications.

Indicator 14: Percent of members with SMI with a focal point of behavioral health care

Description: The percent of members with SMI who have a focal point of care identified and established. For the purpose of this indicator, SMI includes the following: Schizophrenia, Schizoaffective, and Bipolar diagnoses. See Table 8.

Denominator: Total number of unduplicated members meeting the following criteria:

- 21 years of age or older on first day of the measurement period (July 1-June 30)
- Continuously enrolled 12 out of 12 months in the same BHO during the measurement period (SFY)
- Identifying outpatient service with an SMI diagnosis- at least one paid BHO outpatient service (refer to **Table 8**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 8**).
- The type of service identified does not lock the patient into a treatment track for the numerator

Numerator: Total number of members in the denominator that meet at least one of the following track criteria (using **Table 8**) with the same billing provider during the measurement period (SFY).

- Treatment/Recovery Track- At least 3 Treatment/Recovery or Case Management or Med Management visits
- Med Management Track- At least 2 Med Management visits

Data Source(s): BHO transaction system.

Calculation of Measure: BHO

TABLE 8

Codes to Identify BHO Outpatient Services

Service Domain and/or Category	CPT/HCPCS Procedure Code		POS
Assessment	90791, 90792, , H0031, H0001, S9445, S3005, T1007, T1023	**WITH**	**Exclude POS 21, 51 and 23**
Treatment/Recovery (Psychotherapy, Svc planning, Vocational, Peer support)	90846-7, 90849, 90853, H0032, H0004-H0006, H0036-40, H2014-8, H2023–7, H2030-2, 90832, 90834, 90837, T1019		
Case Management	T1016-7		
Med Management	96372, 99441-3, H0020, H0033-4, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510		

Diagnosis Codes

Diagnosis	ICD-9-CM
Schizophrenia	295.10, 295.1, 295.20, 295.2, 295.30, 295.3, 295.60, 295.6, 295.90, 295.9
Schizoaffective disorder	295.70, 295.7
Bipolar disorder	296.0x, 296.40, 296.4, 296.4x, 296.5x, 296.6x, 296.70, 296.7, 296.80, 296.89

Indicator 15: Improving physical healthcare access

Description: The total number of Members who received outpatient mental health treatment during the measurement period and also had a qualifying physical healthcare visit during the measurement period

Denominator: Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least 10 months with the same BHO during the 12-month measurement period. (This is the numerator from the Service Category Penetration Rates measures excluding ED services.)

Numerator: Total number of members in the denominator with at least one preventive or ambulatory medical visit as defined using the service codes in **Table 9** during the measurement period, excluding those services provided by rendering provider type codes identified in **Table 9**.

Data Source(s): The encounter/claims files (BHO, MCO, Fee for Service) for the fiscal year, including paid claims, provided by HCPF

Calculation of Measure: HCPF

Benchmark: Overall BHO

TABLE 9

Preventive or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS 2014)

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337,			
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V20.2,V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Rendering Provider Type Code Exclusions

Rendering Provider Type Code	Rendering Provider Type Description
06	Podiatrist
11	Case Manager
27	Speech Therapist
12	Independent Laboratory

Indicator 16: Inpatient utilization (per 1000 members)

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health diagnosis per 1000 members, by age group (see above for age categories) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12-month period) per HEDIS age group.

Numerator: All discharges from a hospital episode for treatment of a covered mental health diagnosis per HEDIS age group
Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.
All Hospitals: All discharges from a hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30.

Data Source(s): Denominator: Members by BHO provided by HCPF. Numerator: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State hospital

Indicator 17: Hospital length of stay (LOS)

Description: The average length of stay (in days) for BHO members discharged from a hospital episode for treatment of a covered mental health diagnosis, by age group and total population. Two indicators are provided: 1) Average length of stay for members discharged from a non-State hospital episode for treatment of a covered mental health diagnosis during the specific fiscal year, July 1 through June 30 and 2) Average length of stay for members discharged from all hospital episodes for a covered mental health diagnosis during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at hospital discharge.
Please note: For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals should be attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission.

Denominators: Number of Members discharged from a hospital episode per HEDIS age group. The discharge day must occur within the specified fiscal year, July 1 through June 30.
Non-State Hospital: Total number of Members discharged from a non-State hospital during the specified fiscal year
All Hospitals: Total number of Members discharged from all hospitals during the specified fiscal year.

Numerators: Total days for all hospital episodes resulting in a discharge. Discharge day is not counted. The discharge day must occur within the specified fiscal year, July 1 through June 30. If the admit date and the discharge date are the same then the number of days for the episode is one.
Non-State Hospitals: Total days= Discharge date from the non-State hospital-Admit date
All Hospitals: Total days=Discharge date from all hospitals-Admit date

Data Source(s): Denominator: Number of Members discharged, from non-State hospitals and State hospitals, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the state hospital data file. Numerator: Hospital days (discharge date – admit date) from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Hospital days (discharge date – admit date) from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-State hospital)/Denominator (non-State hospital); Numerator (all hospital)/Denominator (all hospital)

Benchmark: BHO for all hospital and non-State hospital

Indicator 18: Emergency department utilization (per 1000 members)

Description: Number of BHO Member emergency room visits for a covered behavioral health diagnosis (include mental health and substance use diagnoses found on page 4) per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure, include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit. ED visit codes include CPT 99281-99285 and 99291-99292 and revenue code 45x.

Data Source(s): Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

Documentation Work Sheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 16, 2015
Reviewer:	David Mabb and Timea Jonas

Data Integration and Control Element	*Met*	*Not Met*	*N/A*	Comments
Accuracy of data transfers to assigned performance measure data repository.				
◆ The Department and the BHO accurately and completely process transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	☒	☐	☐	
◆ Samples of data from the repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
◆ The Department's and the BHO's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	☒	☐	☐	
◆ Actual results of file consolidations or extracts are consistent with results expected from documented algorithms or specifications.	☒	☐	☐	
◆ Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	☒	☐	☐	
◆ Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
If the Department and the BHO use a performance measure data repository, the structure and format facilitate any required programming necessary to calculate and report required performance measures.				
◆ The repository's design, program flow charts, and source codes enable analyses and reports.	☒	☐	☐	
◆ Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and reporting software.				
◆ Documentation governing the production process, including Department and BHO production activity logs and staff review of report runs, is adequate.	☒	☐	☐	
◆ Prescribed data cutoff dates are followed.	☒	☐	☐	
◆ The Department and the BHO retain copies of files or databases used for performance measure reporting in the event that results need to be reproduced.	☒	☐	☐	
◆ The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
◆ The Department's and the BHO's processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix C. Denominator and Numerator Validation Findings for Access Behavioral Care

Reviewer Work Sheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 16, 2015
Reviewer:	David Mabb and Timea Jonas

Denominator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	☒	☐	☐	
◆ Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☒	☐	☐	
◆ The Department and the BHO have correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	
◆ The Department and the BHO have properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	☒	☐	☐	
◆ Parameters required by the specifications of each performance measure are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
◆ Exclusion criteria included in the performance measure specifications have been followed.	☒	☐	☐	
◆ Systems or methods used by the Department and the BHO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	No populations were estimated.

Numerator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ The Department and the BHO have used appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
◆ Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
◆ The Department and the BHO have avoided or eliminated all duplication of counted members or numerator events.	☒	☐	☐	
◆ Any nonstandard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☐	☐	☒	ABC used only standard codes.
◆ Parameters required by the specifications of the performance measure are adhered to (e.g., the measured event occurred during the time period specified or defined in the performance measure).	☒	☐	☐	During the on-site visit, HSAG found that the incorrect data field was captured for the inpatient services. ABC corrected the issue and re-submitted the corrected data file to HSAG for review. HSAG performed primary source verification on the corrected file, and identified no further issues. In addition, as in prior years, for Indicators 8–11 (penetration rates) and Indicator 13 (follow-up appointments within 7 and 30 days after hospital discharge), clarifications of provider types for mental health practitioners should be provided in the scope document.

Encounter Data

The measurement period for these performance measures is July 1, 2013, through June 30, 2014 (FY 2013–2014).

Hospital Recidivism—Indicator 1

Table D-1—Hospital Recidivism *for* Access Behavioral Care

Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Readmissions)	Rate	Denominator (Discharges)	Numerator (Readmissions)	Rate
Child 0–12 Years of Age	7 Days	67	1	1.49%	67	1	1.49%
	30 Days	67	10	14.93%	67	10	14.93%
	90 Days	67	15	22.39%	67	15	22.39%
Adolescent 13–17 Years of Age	7 Days	140	5	3.57%	152	5	3.29%
	30 Days	140	14	10.00%	152	15	9.87%
	90 Days	140	18	12.86%	152	20	13.16%
Adult 18–64 Years of Age	7 Days	453	13	2.87%	505	15	2.97%
	30 Days	453	55	12.14%	505	60	11.88%
	90 Days	453	89	19.65%	505	100	19.80%
Adult 65 Years of Age and Older	7 Days	5	0	0.00%	5	0	0.00%
	30 Days	5	0	0.00%	5	0	0.00%
	90 Days	5	0	0.00%	5	0	0.00%
All Ages	7 Days	665	19	2.86%	729	21	2.88%
	30 Days	665	79	11.88%	729	85	11.66%
	90 Days	665	122	18.35%	729	135	18.52%

Behavioral Health Engagement—Indicator 4

Table D-2—Behavioral Health Engagement (BHE)* *for* Access Behavioral Care						
Population	MH			SUD		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
0–12 Years of Age	1,790	840	46.93%	12	4	33.33%
13–17 Years of Age	1,249	566	45.32%	82	39	47.56%
18–64 Years of Age	6,315	1,864	29.52%	1,610	449	27.89%
65+ Years of Age	236	43	18.22%	34	20	58.82%
Total	9,590	3,313	34.55%	1,738	512	29.46%

* For the FY 2014–2015 Colorado BHO PMV activity, the measure will be validated, but no penalties will be associated with this measure.

Penetration Rates—Indicators 8–11

The penetration rate is a calculation of the percentage of consumers served by the respective BHO out of all Medicaid-eligible individuals within the BHO service area.

Table D-3—Penetration Rates—Overall *for* Access Behavioral Care			
Population	Enrollment*	Members Served	Rate
Overall	139,113	19,843	14.26%

* Expressed as a full time equivalent (FTE), rounded to the nearest integer.

Table D-4—Penetration Rates by Age Category *for* Access Behavioral Care			
	Enrollment*	Members Served	Rate
Children 12 Years of Age and Younger	55,502	3,697	6.66%
Adolescents Between 13 and 17 Years of Age	14,945	2,437	16.31%
Adults Between 18 and 64 Years of Age	60,138	12,986	21.59%
Adults 65 Years of Age or Older	8,528	723	8.48%
Overall	139,113	19,843	14.26%

* Expressed as an FTE, rounded to the nearest integer.

Table D-5—Penetration Rates by Medicaid Eligibility Category *for* Access Behavioral Care			
	Enrollment*	Members Served	Rate
AFDC/CWP Adults	23,879	3,157	13.22%
AFDC/CWP Children	66,316	5,107	7.70%
AND/AB-SSI	11,394	4,479	39.31%
BC Children	3,058	77	2.52%
BC Women	1,645	232	14.11%
BCCP—Women Breast & Cervical Cancer	27	2	7.38%
Buy-In: Working Adults with Disabilities	331	109	32.97%
Foster Care	2,370	958	40.42%
OAP-A	8,229	695	8.45%
OAP-B-SSI	2,090	580	27.76%
Modified Adjusted Gross Income	19,762	4,380	22.16%
Buy-In: Children with Disabilities	14	2	14.21%

* Expressed as an FTE, rounded to the nearest integer.

** Values from the Enrollment and Rate columns are copied directly from the spreadsheets provided by the Department. Since the values in the Enrollment column were rounded to the nearest integer, the percentages listed in the Rate column may not equal actual percentages calculated using the Enrollment and Members Served values.

Follow-up After Hospitalization for Mental Illness—Indicator 13

Table D-6—Follow-up After Hospitalization for Mental Illness *for* Access Behavioral Care							
Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Rate	Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Rate
6–20 Years of Age	7 Days	166	92	55.42%	175	93	53.14%
	30 Days	166	124	74.70%	175	127	72.57%
21–64 Years of Age	7 Days	273	112	41.03%	294	126	42.86%
	30 Days	273	186	68.13	294	203	69.05%
65+ Years of Age	7 Days	3	0	0.00%	3	0	0.00%
	30 Days	3	1	33.33%	3	1	33.33%
Combined Ages	7 Days	442	204	46.15%	472	219	46.40%
	30 Days	442	311	70.36%	472	331	70.13%

Percent of Members With SMI with a Focal Point of Behavioral Health Care—Indicator 14

Table D-7—Percent of Members with SMI with a Focal Point of Behavioral Health Care *for* Access Behavioral Care		
Denominator (# SMI Members)	Numerator (# SMI Members with a Focal Point of Care)	% SMI Members with a Focal Point of Care
2,180	1,870	85.78%

Improving Physical Healthcare Access—Indicator 15

Table D-8—Percent of Members with Physical Health Care Visit *for* Access Behavioral Care		
Denominator (# of Members with 1 or More Mental Health OP Visits)	Numerator (# of Members in Denominator with at least 1 or More Physical Health Visits)	% Mental Health Members with Physical Health Visit
11,664	10,334	88.60%

Inpatient Utilization—Indicator 16

Table D-9—Inpatient Utilization *for* Access Behavioral Care						
Population	Non-State Hospitals			All Hospitals		
	Denominator*	Numerator	Rate per 1,000 Members	Denominator*	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	55,502	67	1.21	55,502	67	1.21
Adolescent 13–17 Years of Age	14,945	140	9.37	14,945	152	10.17
Adult 18–64 Years of Age	60,138	453	7.53	60,138	505	8.40
Adult 65 Years of Age and Older	8,528	5	0.59	8,528	5	0.59
All Ages	139,113	665	4.78	139,113	729	5.24

* Expressed as an FTE, rounded to the nearest integer.

Hospital Average Length of Stay—Indicator 17

Table D-10—Hospital Average Length of Stay (ALOS) *for* Access Behavioral Care						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	ALOS	Denominator	Numerator	ALOS
Child 0–12 Years of Age	67	548	8.18	67	548	8.18
Adolescent 13–17 Years of Age	140	1,246	8.90	152	1,341	8.82
Adult 18–64 Years of Age	453	3,852	8.50	505	10,032	19.87
Adult 65 Years of Age and Older	5	203	40.60	5	203	40.60
All Ages	665	5,849	8.80	729	12,124	16.63

Emergency Department Utilization—Indicator 18

Table D-11—Emergency Department Utilization *for* Access Behavioral Care			
	Denominator*	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	55,502	227	4.09
Adolescent 13–17 Years of Age	14,945	353	23.62
Adult 18–64 Years of Age	60,138	1,436	23.88
Adult 65 Years of Age and Older	8,528	8	0.94
All Ages	139,113	2,024	14.55

* Expressed as an FTE, rounded to the nearest integer.